Genitourinary Medicine

This *Journal,* founded by the Medical Society for the Study of the Venereal Diseases, publishes original work on the investigation and treatment of genitourinary and allied disorders, and review articles, correspondence, and abstracts.

Advice to authors Papers for publication, which will be accepted on the understanding that they have not been and will not be published elsewhere and are subject to editorial revision, should be sent in duplicate to Dr A McMillan, Department of Genitourinary Medicine, Royal Infirmary, Lauriston Place, Edinburgh EH3 9YW. All authors must give signed consent to publication. The editor should be notified of any change of address of the corresponding author. Manuscripts will only be acknowledged if a stamped addressed postcard or international reply coupon is enclosed.

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(1) *Scripts* must be typewritten on one side of the paper in double spacing with ample margins. Two copies should be sent; if a paper is rejected, one copy will be retained.

(2) *Each script* should include, in the following order: a brief summary, typed on a separate sheet, outlining the main observations and conclusions; the text divided into appropriate sections; acknowledgements; tables, each on a separate sheet; and legends for illustrations.

(3) *The title* of the paper should be as brief as possible.

(4) *The number of authors* should be kept to the minimum, and only their initials and family names used.

(5) *Only the institution(s)* where work was done by each author should be stated.

(6) *SI units* are preferred. If old fashioned units are used SI units should be given in parentheses or, for tables and figures, a conversion factor given as a footnote.

(7) *Only recognised abbreviations* should be used.

(8) *Acknowledgements* should be limited to workers whose courtesy or help extended beyond their paid work, and supporting organisations.

(9) *Figures* should be numbered in the order in which they are first mentioned, referred to in the text, and provided with captions typed on a separate sheet. (*Diagrams:* use thick, white paper and insert lettering lightly in pencil. *Photographs:* should be marked lightly on the back with the author's name and indicating the top, and should not be attached by paper clips or pins. They should be trimmed to include only the relevant section (sizes 2¾" or 5¾" wide, maximum 5¾" × 7") to eliminate the need for reduction. Photomicrographs must have internal scale markers. *X* ray films should be submitted as photographic prints, carefully prepared so that they bring out the exact point to be illustrated.

(10) *Tables* should be numbered, have titles, and be typed on separate sheets. Please avoid large tables.

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I hope that the book will be read by its target audience. It will be an invaluable help to house officers, registrars in urology, and those taking higher examinations, though it will have limited appeal to general practitioners because most of the investigations required are hospital based. The presentation is clear, though at times I found it rather heavy going. Apart from the odd typographical error, mistakes are few.

I was rather sad that in a pocket book of urology there is no chapter on sexually transmitted disease, which is a growing problem, except for a passing word or two on prostatitis and epididymo-orchitis. I was delighted to see a few paragraphs on impotence, which is a recognised problem that should be referred to psychosexual counsellors as suggested by the author.

The book should certainly be available in hospital libraries and departments of urology, and for those who are on the periphery of urology it is an excellent way of keeping up to date.

R B Roy

Notices

Organisers of meetings who wish to insert notices should send details to the editor (address on the inside front cover at least eight months before the date of the meeting or six months before the closing date for application.

First international conference on homosexuality and medicine

The first international conference on homosexuality and medicine will take place in London on 14 to 16 August 1986. Programmes, registration forms, and abstract forms may be obtained from the GMA Secretariat, c/o Caroline Roney Medical Conference Organisers. 100 Park Road, London NW1 4RN (tel: 01 723 6722).

Eighth international meeting of dermatological research

The eighth meeting devoted to dermatological research will be held under the auspices of the Société de Recherche Dermatologique in Nantes. France on 9 to 11 October 1986. The meeting will be organised by the department of dermatology, Centre Hospitalier Régional de Nantes, Hôtel-Dieu, Nantes, France (Director, Professor H Barrière). Further information, abstract forms, and application forms may be obtained from Dr JF Stalder, CARD Service de Dermatologie, CHU 44035 Nantes, France.

Australian scientific congress on sexually transmissible diseases

An Australian scientific congress on sexually transmissible diseases (including the acquired immune deficiency syndrome (AIDS)), hosted by the Venereology Society of New South Wales on behalf of the National Venereology Council of Australia, will be held at Westmead Hospital, Sydney, Australia on 15 to 17 August 1986.

Papers and poster presentations are invited. Enquiries to the conveners, Dr Colin MacLeod, Microbiology Department, ICPMR, Westmead Hospital, Westmead 2145, Australia, (telephone (02) 633 6255) or Dr John Moran, Sexual Health Clinic, Parramatta Hospital, Parramatta 2150, Australia (telephone (02) 635 0333 extension 293).

List of current publications

These selected abstracts and titles from the world literature are arranged in the following sections:

Syphilis and other treponematoses

The ultrastructure of *Treponema pallidum* isolated from human chancres: morphologic variation from Nichol's strain

A POULSEN, T KOBAYASI, L SECHER, AND K WEISMANN (Copenhagen, Denmark). *Acta Derm Vernereol (Stockh)* 1985;**65**:367-73.

Gonorrhoea

Lectin characterization of gonococci from an outbreak caused by penicillin-resistant *Neisseria gonorrhoeae*

WO SCHALLA, RJ RICE, JW BIDDLE, Y JEANLOUIS, SA LARSEN, AND WL WHITTINGTON (Atlanta, USA) *J Clin Microbiol* 1985;**22**:481-3.

Difficulties in differentiating *Neisseria cinerea* from *Neisseria gonorrhoeae* in rapid systems used for identifying pathogenic *Neisseria* species

JM BOYCE AND EB MITCHELL (Jackson, USA). *J Clin Microbiol* 1985;**22**:731-4.

Evaluation of a DNA-hybridization method for detection of African and Asian strains of *Neisseria gonorrhoeae* in men with urethritis

PL PERINE, PA TOTTEN, KK HOLMES, *ET AL* (Bethesda, USA). *J Infect Dis* 1985;**152**:59-63.

Autoplaquing in *Neisseria gonorrhoeae*

LA CAMPBELL, HB SHORT, FE YOUNG, AND VL CLARK (Rochester, USA). *J Bacteriol* 1985;**164**:461-5.

Antibody-antigen specificity in the immune response to infection with *Neisseria gonorrhoeae*

CJ LAMMEL, RL SWEET, PA RICE, *ET AL* (San Francisco, USA). *J Infect Dis* 1985;**152**: 990-1001.

Gonococcal resistance to antibiotics

CSF EASMON (London, England). *J Antimicrob Chemother* 1985;**16**:409-12.

Non-specific genital infections and related disorders (chlamydial infections)

Cervical *Chlamydia trachomatis* infection in university women: relationship to history, contraception, ectopy and cervicitis

HR HARRISON, M COSTIN, JB MEDER, *ET AL* (Atlanta, USA). *Am J Obstet Gynecol* 1985;**153**:244-51.

Ectopic pregnancy and antibodies to *Chlamydia trachomatis*

L SVENSSON, P-A MÅRDH, M AHLGREN, AND F NORDENSKJÖLD (Lund, Sweden). *Fertil Steril* 1985;**44**:313-7.

Isolation of *Chlamydia trachomatis* from the prostatic cells in patients affected by nonacute abacterial prostatitis

F POLETTI, MC MEDICI, A ALINOVI, *ET AL* (Parma, Italy). *J Urol* 1985;**134**:691-3.

Thirty patients with a clinical and microbiological diagnosis of "non-acute abacterial prostatitis" were selected for investigation of the relation between urethral infection with *Chlamydia trachomatis* and subsequent prostatitis. They were aged 21-50 (mean 34) years, had a positive anterior urethral culture for *C trachomatis*, and had not received antibiotics for the preceding three months. Protracted histories were common, with 73% of the group having had symptoms for more than 12 months.

The patients were investigated using a Franzen needle transrectal prostatic aspiration technique. This is described as causing "minimal discomfort and no side effects". The interval between urethral culture and prostatic aspiration was not recorded. The aspiration technique appears to have been variable, and on occasion tender areas of prostate were explored. Insertion was described as "deep", and was followed by uninterrupted aspiration to obtain cells from several layers of both prostatic lobes. Using cyclohexomide treated McCoy cell cultures chlamydiae were isolated in 10 out of 30 aspirates, three of which proved toxic to McCoy cells. This 33% culture positivity in non-acute prostatitis seems to be high, but all had proved active anterior urethral disease with the same organism. The hypothetical possibility of contamination from the rectal mucosa was not excluded. Sexual questionnaires showed a high proportion of patients (40%) complaining of premature ejaculation and 33% complaining of erectile difficulty — a surprising observation.

This is an interesting study into a common and difficult clinical syndrome. Further work should include a larger group of patients fulfilling agreed criteria for the diagnosis of prostatis without selection by positive anterior urethral culture, and should also include the serological and culture investigation of sexual partners.

T R Moss

Frequency of *Chlamydia trachomatis* as the cause of pharyngitis

H HUSS, D JUNGKIND, P AMADIO, AND I RUBENFELD (Philadelphia, USA). *J Clin Microbiol* 1985;**22**:858-60.

Effect of swab type and storage temperature on the isolation of *Chlamydia trachomatis* from clinical specimens
JB MAHONEY AND MA CHERNESKY (Hamilton, Canada). *J Clin Microbiol* 1985;**22**:865-7.

Detection of multiple serovars of *Chlamydia trachomatis* in genital infections
RC BARNES, RJ SUCHLAND, S-P WANG, C-C KUO, AND WE STAMM (Seattle, USA). *J Infect Dis* 1985;**152**:985-9.

Immunotyping of *Chlamydia trachomatis* with monoclonal antibodies
S-P WANG, C-C KUO, RC BARNES, RS STEPHENS, AND JT GRAYSTON (Seattle, USA). *J Infect Dis* 1085;**152**:791-800.

Enzyme amplified immunoassay: a novel technique applied to direct detection of *Chlamydia trachomatis* in clinical specimens
SF PUGH, RCB SLACK, EO CAUL, ID PAUL, PN APPLETON, AND S GATLEY (Nottingham, England). *J Clin Pathol* 1985;**38**:1139-41.

Differences in outer membrane proteins of the lymphogranuloma venereum and trachoma biovars of *Chlamydia trachomatis*
BE BATTIGER, WJ NEWHALL, AND RB JONES (Indianapolis, USA). *Infect Immun* 1985;**50**:488-94.

New view of the surface projections of *Chlamydia trachomatis*
BA NICHOLS, PY SETZER, F PANG, AND CR DAWSON (San Francisco, USA). *J Bacteriol* 1985;**164**:344-9.

Neutralization of *Chlamydia trachomatis* cell culture infection by serovar-specific monoclonal antibodies
ME LUCERO AND C-C KUO (Seattle, USA). *Infect Immun* 1985;**50**:595-7.

Erythromycin against *Chlamydia trachomatis* infections: a double blind study comparing 4- and 7-day treatment in men and women
A-M WORM, C AVNSTORP, AND CS PETERSEN (Copenhagen, Denmark). *Dan Med Bull* 1985;**32**:269-71.

Reiter's disease

Complete heart block in Reiter's syndrome
NH THOMSEN, K HØRSLEV-PETERSEN, AND EE SIMONSEN (Haderslev, Denmark). *Dan Med Bull* 1985;**32**:272-3.

Trichomoniasis

Geographic variation among isolates of *Trichomonas vaginalis:* demonstration of antigenic heterogeneity by using monoclonal antibodies and the indirect immunofluorescence technique
JN KRIEGER, KK HOLMES, MR SPENCE, MF REIN, WM McCORMACK, AND MR TAM (Seattle, USA). *J Infect Dis* 1985;**152**:979-84.

Identification of a surface antigen of *Trichomonas vaginalis*
RJ CONNELLY, BE TORIAN, AND HH STIBBS (Seattle, USA). *Infect Immun* 1985;**49**:270-4.

Genital herpes

Detection of herpes simplex virus in women with acute pelvic inflammatory disease
M LEHTINEN, I RANTALA, K TEISALA, *ET AL (Tampere, Finland). J Infect Dis* 1985;**152**:78-82.

Epidemiology of genital herpes simplex virus infection
ME GUINAN, SM WOLINSKY, AND RC REICHMAN (Atlanta, USA). *Epidemiol Rev* 1985;**7**:127-46.

Analysis of world-wide age-specific data for the association of cervical cancer with infections by herpes simplex virus type 2
J CAMPIONE-PICCARDO (Hamilton, Canada). *Med Hypotheses* 1985;**16**:333-50.

Comparison of the detection of herpes simplex virus in direct clinical specimens with herpes simplex virus-specific DNA probes and monoclonal antibodies
JC FUNG, J SHANLEY, AND RC TILTON (Farmington, USA). *J Clin Microbiol* 1985;**22**:748-53.

Humoral immune response to HSV-1 and HSV-2 proteins in patients with primary genital herpes
R ASHLEY, J BENEDETTI, AND L COREY (Seattle, USA). *J Med Virol* 1985;**17**:153-66.

Humoral immune response to herpes simplex virus type 2 glycoproteins in patients receiving a glycoprotein subunit vaccine
R ASHLEY, G MERTZ, H CLARK, M SCHICK, D SALTER, AND L COREY (Seattle, USA). *J Virol* 1985;**56**:475-81.

Thymopentin treatment of herpes simplex infections: an open, monitored, multicentre study
J de MAUBEUGE, E HANEKE, D DJAWARI, *ET AL (Brussels, Belgium). Survey of Immunological Research* 1985;**4** (suppl 1):30-6.

Genital warts

Massive vulval condylomata acuminata in a 10-months-old child with suspected sexual abuse. Case report
O SADAN, AB KOLLER, A ADNO, AND PG BEALE (Johannesburg, South Africa). *Br J Obstet Gynaecol* 1985;**92**:1201-3.

Pruritic vulvar squamous papillomatosis: evidence for human papillomavirus etiology
WA GROWDON, YS FU, TB LEBHERZ, A RAPKIN, GD MASON, AND G PARKS (Los Angeles, USA). *Obstet Gynecol* 1985;**66**:564-8.

Genital warts, human papillomaviruses, and cervical cancer
LEADING ARTICLE *Lancet* 1985;ii:1045-6.

Natural history of cervical human papillomavirus (HPV) infections based on prospective follow-up
K SYRJÄNEN, M VÄYRYNEN, S SAARIKOSKI, *ET AL (Kuopio, Finland). Br J Obstet Gynaecol* 1985;**92**:1086-92.

Human papillomavirus types 6 and 16 in multifocal intraepithelial neoplasias of the female lower genital tract
DJ McCANCE, PK CLARKSON, JL DYSON, PG WALKER, AND A SINGER (London, England). *Br J Obstet Gynaecol* 1985;**92**:1093-100.

Prevalence of human papillomavirus type 16 DNA sequences in cervical intraepithelial neoplasia and invasive carcinoma of the cervix
DJ McCANCE, MJ CAMPION, PK CLARKSON, PM CHESTERS, D JENKINS, AND A SINGER (London, England). *Br J Obstet Gynaecol* 1985;**92**:1101-5.

Comparison of podophyllin application with simple surgical excision in clearance and recurrence of perianal condylomata acuminata
SL JENSEN (Copenhagen, Denmark). *Lancet* 1985;ii:1146-8.

Acquired immune deficiency syndrome

International confernece on acquired immunodeficiency syndrome, 14-17 April 1985, Atlanta, Georgia
SPONSORED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE WORLD HEALTH ORGANIZATION, IN COOPERATION WITH EMORY UNIVERSITY SCHOOL OF MEDICINE AND THE MOREHOUSE SCHOOL OF MEDICINE *Ann Intern Med* 1985;**103**:653-781.

Acute glandular fever-like illness in a patient with HTLV-III antibody
TF McCAUL, G TOVEY, CF FARTHING, B GAZZARD, AND AJ ZUCKERMAN (London, England). *J Med Virol* 1985;**17**:179-93.

Acute encephalopathy coincident with seroconversion for anti-HTLV-III
CA CARNE, RS TEDDER, A SMITH, *ET AL (London, England). Lancet* 1985;ii:1206-8.

Inflammatory neuropathy in homosexual men with lymphadenopathy
WI LIPKIN, G PARRY, D KIPROV, AND D ABRAMS (La Jolla, USA). *Neurology (NY)* 1985;**35**:1479-83.

Salmonella bacteremia associated with the acquired immunodeficiency syndrome (AIDS)
RB NADELMAN, U MATHUR-WAGH, SR YANCOVITZ, AND D MILDVAN (New York, USA). *Arch Intern Med* 1985;**145**:1968-71.

Adrenal pathology in the acquired immune deficiency syndrome
BJ GLASGOW, KD STEINSAPIR, K ANDERS, AND LJ LAYFIELD (Los Angeles, USA). *Am J Clin Pathol* 1985;**84**:594-7.

Granulomatous inflammation in the acquired immune deficiency syndrome
V JAGADHA, RH ANDAVOLU, AND CT HUANG (New York, USA). *Am J Clin Pathol* 1985;**84**:598-602.

Epidemiology of the acquired immunodeficiency syndrom (AIDS)
TA PETERMAN, DP DROTMAN, AND JW CURRAN (Atlanta, USA). *Epidemiol Rev* 1985;**7**:1-21.

Antibodies to human T cell lymphotropic virus type III in promiscuous healthy homosexual men. Relation to immunological and clinical findings
J GESTOFT, BO LINDHARDT, CS PETERSEN, *ET AL (Copenhagen, Denmark). Eur J Clin Invest* 1985;**15**:290-5.

Heterosexually acquired HTLV-III/LAV disease (AIDS-related complex and AIDS): epidemiologic evidence for female-to-male transmission
RR REDFIELD, PD MARKAM, SZ SALAHUDDIN, DC WRIGHT, MG SARNGADHARAN, AND RC GALLO (Bethesda, USA). *JAMA* 1985;**254**:2094-6.

Seroepidemiological studies of HTLV-III antibody prevalence among selected groups of heterosexual Africans
N CLUMECK, M ROBERT-GUROFF, P van de PERRE, *ET AL (Brussels, Belgium). JAMA* 1985;**254**:2599-602.

Antibodies to HTLV-III/LAV among aboriginal Amazonian Indians in Venezuela
L RODRIQUEZ, S DEWHURST, F SINANGIL, F MERINO, G GODOY, AND DJ VOLSKY (Omaha, USA). *Lancet* 1985;ii:1098-100.

The presence of endemic human T lymphotropic virus type III or lymphadenopathy virus (HTLV-III/LAV) in the tropical belt of Africa prompted the authors to study its presence in a similar area in South America, the remote Amazonian regions of Venezuela inhabited by aboriginal Indians. Of 224 serum samples collected from four different ethnic groups in 1968-9 and 1984-5 and tested by indirect immunofluorescence, western blotting, and radioimmunoprecipitation tests, three out of 150 (3·3%) Yanoama Indians, two out of 54 (3·7%) Makiritare Indians, and two out of 15 (13·3%) Pemon Indians were seropositive for HTLV-III/LAV antibodies by all three assays. Mean titres ranged between 1/60 and 1/200 and the ages of patients from 10 to 70 years. Five of the nine seropositive people were women, and a 70-year-old woman had one of the highest titres. Three of the positive serum samples had been collected in 1968 and were all from the Yanoama Indians. All patients were apparently healthy at the time blood was collected. Two of the seropositive people also had antibodies to HTLV-I virus, which is endemic in Venezuela. Control serum samples obtained from 211 randomly chosen healthy blood donors in seven Venezuelan cities were all negative for HTLV-III/LAV antibodies.

The remoteness and the isolation of the aboriginal Indians and the absence of seropositivity in rural blood donors indicate exposure to an indigenous HTLV-III/LAV or a closely related cross reactive virus, rather than to an external source. They also had similarities to seropositive Africans, such as low titres, and absence of AIDS like disease, random distribution of age, and exposure to parasitic infection.

It will be interesting to know whether the nine seropositive people included sexual partners and children of seropositive women and whether the HTLV-III like retrovirus, which was isolated from macaques in the old world, will be isolated in South American non-human primates.

K M Saravanamuttu

LAV/HTLV-III infection in female prostitutes
G PAPAEVANGELOU, A ROUMELIOTOU-KARAYANNIS, G KALLINIKOS, AND G PAPOUTSAKIS (Athens, Greece). *Lancet* 1985;ii:1018.

Transmission of human T cell lymphotropic virus type III (HTLV-III) by artificial insemination by donor
GJ STEWART, JPP TYLER, AL CUNNINGHAM, *ET AL (Sydney, Australia). Lancet* 1985;ii:581-5.

Four out of eight women who received cryopreserved semen from an anti-HTLV-III/LAV positive bisexual man became infected with HTLV-III/LAV and developed antibodies that were assayed using a direct ELISA and confirmed by western blot. One had persistent generalised lymphadenopathy and the other three were asymptomatic three years after insemination. The women had no other risk factor for HTLV-III/LAV infection. All four husbands remained antibody negative despite regular sexual contact, without the use of condoms, for up to three years. Three of the women became pregnant and the children, all over 1 year old at the time of the study, were well and anti-HTLV-III/LAV negative.

The virus is likely to be predominantly within T4 lymphocytes, cells for which glycerol cryopreservation is suboptimal, and there appeared to be an association between short duration of storage and transmission. As seroconversion has been reported up to 56 days after exposure, semen samples should be cryopreserved for at least three, perhaps six, months and the donor retested before they are used.

Before accurate estimations of the risk of HTLV-III/LAV infection in the heterosexual and neonatal setting can be made,

some quantitative estimation of index case infectivity is required. We have yet to develop this for HTLV-III/LAV infection.

I V D Weller

LAV/HTLV-III in 20-week fetus

E JOVAISAS, MA KOCH, A SCHÄFER, M STAUBER, AND D LÖWENTHAL (Berlin, Federal Republic of Germany). *Lancet* 1985;ii:1129.

HTLV-III infection among health care workers: association with needle-stick injuries

SH WEISS, C SAXINGER, D RECHTMAN, *ET AL (Bethesda, USA). JAMA* 1985;**254**:2089-93.

Human T-cell leukemia/lymphotropic virus type III in the conjunctival epithelium of a patient with AIDS

LS FUJIKAWA, SZ SALAHUDDIN, D ABLASHI, *ET AL (Bethesda, USA). Am J Ophthalmol* 1985;**100**:507-9.

The impact of the AIDS epidemic on corneal transplantation

JS PEPOSE, S MacRAE, TC QUINN, AND GN HOLLAND (Baltimore, USA). *Am J Ophthalmol* 1985;**100**:610-3.

HTLV-III antibody in Edinburgh drug addicts

JF PEUTHERER, E EDMOND, P SIMMONDS, JD DICKSON, AND GE BATH (Edinburgh, Scotland). *Lancet* 1985;ii:1129-30.

Primary lymph node pathology in AIDS and AIDS-related lymphadenopathy

EP EWING, FW CHANDLER, TJ SPIRA, RK BRYNES, AND WC CHAN (Atlanta, USA). *Arch Pathol Lab Med* 1985;**109**:977-81.

Lymph nodes of patients symptomatically infected with the acquired immune deficiency syndrome (AIDS) virus show a range of morphological changes from pronounced lymphoid hyperplasia to great lymphocytic depletion. These changes can be grouped into three distinct patterns. The type I pattern features follicular and paracortical hyperplasia and is associated with chronic lymphadenopathy. The type II pattern, which shows diffuse lymphoid hyperplasia but loss of germinal centres, signifies evolution of chronic lymphadenopathy to AIDS. The type III pattern shows great lymphocytic depletion and represents the end stage lymph node seen in fatal AIDS. These histological patterns are closely correlated with the clinical and immunological status of patients infected with the AIDS virus.

Authors' summary

Nonbronchoscopic bronchoalveolar lavage for the diagnosis of *Pneumocystis carinii* pneumonia in the acquired immunodeficiency syndrome

G CAUGHEY, H WONG, G GAMSU, AND J GOLDEN (San Francisco, USA). *Chest* 1985;**88**:659-62.

Ultrastructural markers in circulating lymphocytes of subjects at risk for AIDS

JM ORENSTEIN, GL SIMON, CM KESSLER, AND RS SCHULOF (Washington, USA). *Am J Clin Pathol* 1985;**84**:603-9.

A new HTLV-III/LAV encoded antigen detected by antibodies from AIDS patients

JS ALLAN, JE COLIGAN, T-H LEE, *ET AL (Boston, USA). Science* 1985;**230**:810-3.

Importance of western blot analysis in predicting infectivity of anti-HTLV-III/LAV positive blood

JI ESTEBAN, J W-K SHIH, C-C TAI, AJ BODNER, JWD KAY, AND HJ ALTER (Bethesda, USA). *Lancet* 1985;ii:1083-6.

Thymopentin treatment in AIDS and pre-AIDS patients

N CLUMECK, S CRAN, P van de PERRE, F MASCART-LEMONE, J DUCHATEAU, AND K BOLLA (Brussels, Belgium). *Survey of Immonological Research* 1985;**4**(suppl 1):58-62.

Other sexually transmitted diseases

Role of lipopolysaccharide and complement in susceptibility of *Haemophilus ducreyi* to human serum

JA ODUMERU, GM WISEMAN, AND AR RONALD (Winnipeg, Canada). *Infect Immun* 1985;**50**:495-9.

Comparative study of ceftriaxone and trimethoprim-sulfamethoxazole for the treatment of chancroid in Thailand

DN TAYLOR, C PITARANGSI, P ECHEVERRIA, K PANIKABUTRA, AND C SUVONGSE (San Francisco, USA). *J Infect Dis* 1985;**152**:1002-6.

Cultural factors and transmission of hepatitis B virus

L BRABIN AND BJ BRABIN (Madang, Papua New Guinea). *Am J Epidemiol* 1985;**122**:725-30.

Altered natural history of hepatitis B in homosexual males – a reflection of altered immune responsiveness?

MG ANDERSON, ALWF EDDLESTON, AND IM MURRAY-LYON (London, England). *J Med Virol* 1985;**17**:167-73.

Prevention of perinatal acquisition of hepatitis B virus carriage using vaccine: preliminary report of a randomized, double-blind placebo-controlled and comparative trial

Z-Y XU, C-B LIU, AND DP FRANCIS (Atlanta, USA). *Pediatrics* 1985;**76**:713-8.

The epidemiology of cytomegaloviral infection in women attending a sexually transmitted disease clinic

SH CHANDLER, KK HOLMES, BB WENTWORTH, *ET AL (Seattle, USA). J Infect Dis* 1985;**152**:597-605.

In a study to test the hypothesis that cytomegalovirus (CMV) is sexually transmitted, selected women attending a sexually transmitted diseases (STD) clinic were examined repeatedly by cervical culture and serological tests for CMV infection. At initial testing, seropositivity to CMV (complement fixating antibody titre greater than or equal to 1/8) was found in 180 out of 328 (55%), rising after follow up visits to a cumulative total of 200 out of 340 (59%). Stepwise multivariate logistic regression analysis showed that seropositivity was most closely associated with the number of sexual partners in the patient's lifetime ($p<0{\cdot}0001$) and young age at first intercourse ($p=0{\cdot}0002$). Cytomegalovirus was isolated on culture from 84 seropositive women at some stage during the study. Those who shed virus were younger than the culture negative women ($p=0{\cdot}0007$) and had been sexually active for fewer years ($p=0{\cdot}008$). This is compatible with the theory that virus shedding (with concomitant risk of sexual transmission) is more common in women with recent primary CMV infection compared with those infected for a longer period of time. Concurrent chlamydial infection of the cervix also correlated with the shedding of CMV ($p=0{\cdot}016$). The importance of this association requires further investigation. Eleven initially seronegative women developed culture or serological changes consistent with primary CMV infection. In these women levels of sexual activity were generally higher than in those who were initially seronegative and who remained so during follow up.

The authors of this study present convincing evidence in support of the hypothesis that CMV is sexually transmissible and that

sexual contact is an important mode of transmission in some heterosexual young adults. As the authors themselves point out, however, extrapolation to all heterosexual women is not possible as members of the study group were highly selected and 219 (63%) of them had initially been enrolled for another study for bacteriological and virological evaluation of mucopurulent cervical discharge or cervical ectopy. In addition, incomplete follow up in many instances has caused bias in some results. Further prospective studies in unselected populations are required.

G R Scott

Genitourinary bacteriology

Prevalence of seven microorganisms in abnormal vaginal secretions (vaginitis)
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